DOCUMENT RESUME

ED 479 320 CG 032 525

AUTHOR	Chambliss, Catherine; Oxman, Elaine
TITLE	Customizing Group Therapy.
PUB DATE	2003-00-00
NOTE	16p.; Based on a workshop presented at the June 2003 Pennsylvania Psychological Association Meeting.
PUB TYPE	Reports - Descriptive (141) -- Reports - Research (143)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	Cost Effectiveness; Counseling Effectiveness; *Counseling Techniques; *Group Experience; *Group Therapy; *Individual Needs; *Individualized Programs; Outcomes of Treatment

ABSTRACT

The group therapy context provides unparalleled opportunities for cost effective learning. However, within group meetings, therapists must strive to tailor psychological services to address the particular needs of individual patients. Creative means of customizing patients' experiences within group are needed in order to address consumer needs appropriately, while simultaneously curbing costs. Staffing limitations mandate flexible use of group methods and enthusiastic adaptation of treatment methods originally developed for individual therapy delivery. Several strategies for customizing treatment within a cost-effective group context will be presented. (Author)

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Customizing Group Therapy

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Abstract

The group therapy context provides unparalleled opportunities for cost effective learning. However, within group meetings, therapists must strive to tailor psychological services to address the particular needs of individual patients. Creative means of customizing patients' experiences within group are needed in order to address consumer needs appropriately, while simultaneously curbing costs. Staffing limitations mandate flexible use of group methods and enthusiastic adaptation of treatment methods originally developed for individual therapy delivery. Several strategies for customizing treatment within a cost-effective group context will be presented.

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Introduction

As a result of ongoing reductions in staffing complements in community mental health centers, substance use treatment centers, and psychiatric hospitals, psychologists are increasingly encouraged to provide group psychotherapy rather than individual therapy. Given the pressures to (1) maintain high levels of consumer satisfaction, (2) provide rapid stabilization of functioning and effective relapse prevention interventions, and (3) include all patients in active treatment, therapists are compelled to experiment with innovative ways of using group psychotherapy methods.

Augmenting these already daunting challenges are changes in modal patient characteristics. Residents of inpatient programs present increasingly severe and persistent problems in inpatient treatment settings. Thanks in part to managed behavioral healthcare systems, hospitalization is the treatment of last resort, increasingly reserved for cases involving extremely volatile and potentially dangerous behaviors, where risk of symptom exacerbation during the course of treatment is high (Chambliss, 2000). In outpatient settings, symptom severity has also increased. Many severely ill consumers whose needs were formerly addressed through inpatient care are now limited to outpatient treatment options.

Addressing these challenges requires innovative applications of traditional interventions (including social skills training, assertiveness training, relaxation training, supportive reflection, and cognitive behavioral techniques) and newer therapeutic approaches (including solution focused methods, pharmacotherapy education, and cognitive engagement techniques). Variable levels of patient functioning often make it difficult to engage all members of groups in collaborative activities. High demands for attention on the part of some group members can prove disruptive to the group experience. Special group strategies are needed simultaneously to meet the needs of active patients requiring a great deal of redirection, the needs of passive, fearful, and withdrawing patients who need to be coaxed to participate, and the needs of eager patients seeking positive shared group experiences. It is also important to structure group discussions so as to avoid symptom contagion.

One of the most significant drawbacks of inpatient care involves its isolation of clients from opportunities to experience outside social, occupational, and educational successes. All too often, hospitalization transforms a client's identity by emphasizing pathological behavior (Chambliss, 1988; Chambliss, 2000). The challenge for group therapists is to strengthen existing client competencies in a context that threatens to reinforce passivity and negative attention-seeking behaviors. While various positive behaviors occurring spontaneously in the unit residence provide regular opportunities for group leaders to highlight clients' achievements, interviews with patients revealed that many felt most proud of accomplishments while on pass or while involved in various formal off-unit activities.

In order to build upon this pride and to emphasize the patients' successful functioning away from the formal treatment unit, the decision was made to make discussions of outside successes a consistent part of group therapy meetings. More

systematic integration of such off-unit experiences was also expected to increase generalization of treatment gains, by increasing perceived self efficacy and emphasizing skill performance off the unit. Since most clients were already being encouraged by their treatment teams to participate in various off-unit experiences (offered as part of a treatment mall program, a supervised workshop program, a consumer center, and a greenhouse patient worker program), it was possible to revise group meetings with the explicit purpose of building on clients' off-unit success experiences. In order to achieve this objective, several group interventions aimed at systematically integrating off-unit experiences were evaluated.

Because of rapid patient turnover in today's treatment settings, it is generally unfeasible to develop and maintain homogeneous groups of patients. Although empirically supported treatment methods must be provided, it is rare to encounter groups whose members all share the same diagnosis and co-diagnoses. Group composition shifts from week to week, making it necessary to use a modular approach to treatment that does not require continuity that can not be guaranteed. These various realities help to make delivering group psychotherapy in these inpatient contexts both exciting and stimulating; no two weeks are ever the same, and creative flexibility is always necessary.

Innovative means of tailoring group meetings to address widely varying patient needs, and to supply various specific treatment interventions, are increasingly crucial. This study involved a preliminary assessment of several group techniques. The goal was to offer more energizing, positive, individualized treatment experiences within a cost-effective group format. The strategies were developed to maximize group involvement, foster various competencies, facilitate peer relationships, and to enhance the generalization of group therapy experiences to settings beyond the treatment site, as well as to encourage involvement in various work and training opportunities by offering explicit reinforcement for these activities in the group therapy setting. This attempt to integrate various elements of care was intended to tailor the treatment experience more closely to the specific needs of individual inpatients, while increasing the efficiency of the treatment process. Several strategies for customizing group therapy will be reviewed.

Selected Strategies for Customizing Care:
Modifying relevant empirically supported interventions for groups

SIMPLIFY THE MESSAGE!

ILLUSTRATE THE MESSAGE!

REVIEW THE MESSAGE!

Person-centered Empathy strategies: Crisis management & Emergencies

Sample interventions:

That's gotta be very frustrating.
I can see this is really bothering you.
It seems like you're having a rough day.
What can we do to help?

IPT & Contextual Strategies: Interpersonal Crisis & strife

Sample interventions:

It seems like s/he was having a bad day.
Do you think s/he wished it had gone better?
What kinds of things can you reasonably expect here?
What can you do to help bring out her/his best?

Solution Focused Strategies: Combatting the "sick role"

Sample interventions:

What might make this work better for you?
What's helped before with this king of thing?
How have you gotten through this before?
When do things tend to go better for you?

Behavioral Strategies: Developing basic coping & problem solving skills

Relaxation Techniques
Exposure Methods
Assertiveness Training
Self Reward Programs

Cognitive Strategies: Challenging Depressive Thinking

Sample interventions:

Have you gone through anything like this before?
Maybe this is temporary (This too shall pass).
(Reducing problems linked to stable vs unstable attributions)

Not all people are like this
Not all days go this badly.
(Reducing problems linked to global vs specific attributions)

It seems you've done what you can here.
Maybe anyone in this situation would find it challenging.
(Reducing problems linked to internal vs external attributions)

When life hands you lemons, make lemonade!
How might this change add to your life?
Reframing

Psychopharmacotherapy Strategies: Supporting Biological Treatments

Sample interventions:

Why are your medications important?
What helps reduce side effects for you?

Education & relapse prevention

Sample interventions:

What helps you maintain your meds?
What are the best substance (alcohol & drug) use choices for you?

Additional Group Strategies for Tailoring Treatment

In addition to using the sample interventions described above, several techniques previously found to be helpful were employed in running the treatment groups during the target period. One strategy involved developing a cumulative PowerPoint presentation summarizing the lessons emphasized in each week's treatment meeting. Patients collaborated in formulating and typing slides for the presentation. They also assisted in animating their work (see Appendix 1).

A second strategy used in this study provided a means of offering members, on a rotating basis, to be "Star for a Day" with certain group meetings. This strategy makes one individual the special focus of part of the group session, and provides them with the opportunity to reflect on their recent and past successes, and to discuss how the various elements of their treatment experience (both on-unit and off-unit) are contributing to their achievement of treatment objectives. We often develop various programs with a clear rationale in mind, but often patients are unaware of the consequences we intend their efforts to have. By helping patients to see that acquiring and practicing basic employment skills we are hoping to help them eventually locate and obtain a parttime job, therapists

can help sustain their motivation to participate in sheltered workshop and other supervising work settings. Explaining that the objective of employment may be as much intended to provide structure and socialization opportunities for them as it is intended to address financial concerns can help to reduce some patients' resistance to the idea of working. Some hospitalized patients feel that it is unfair to expect them to hold down a job, even a parttime one, because of the burdens imposed by their illnesses. Helping them see that finding the right type of parttime work may be in their best psychological interest can help increase the likelihood of their staying engaged in relevant training programs.

When the "Star for a Day" tactic is used, the individual occupying this special role alternates, so that over several weeks' time, every member gets the opportunity to receive this focused attention. The patient selected is asked to suggest a particular concern, area of need, or individual treatment objective. Other members serve as therapeutic assistants in helping the leader develop strategies for addressing the individual patient's specific needs.

A third strategy, Peer Mentoring, extended the use of peers beyond the formal group meeting period. Part of the group time is used to plan and structure supportive learning activities for dyads of patients to share in between formal group meetings. Group members discuss plans for shared activities outside of the group, and their joint ventures are facilitated by the group leader. Progress in initiating and pursuing these planned activities is assessed at the beginning of each group meeting.

A fourth strategy involves use of Goal Group sessions, which permit patients to discuss specific behavioral objectives (e.g., what they need to do while in the hospital in order to facilitate discharge; what they can do to manage their illness to prevent relapse, etc.). The psychologist can praise patients who show even minimal progress, and can structure the discussion to encourage mutual support of appropriate behavior. A common goal of discharge or relapse prevention may unite all members, while the individual obstacles to this goal are being addressed. Specific opportunities to address how off-site experiences can contribute to the achievement of common goals can help to increase individual patients' motivation, and can also foster the creation of mutually supportive groups of patients who choose to get involves together in common off-unit activities.

A fifth strategy, particularly important in very large groups, is to make use of interdisciplinary interventions within group meetings. Incorporation of music, art, dance, exercise, budgeting, and cooking activities can help maintain patients' enthusiasm for the large group experience. Providing positive experiences that stimulate various sensory modalities can increase subsequent engagement in more traditional problem solving discussions. In addition, learning how to make positive use of leisure time is important to these patients' eventual discharge success.

A sixth strategy involved use of a "pull out" component, which provided for brief individual meetings with all members to supplement the common group experience. Awareness of this option helped to diffuse several tense situations when particular topics could not be addressed communally (e.g., one patient was needed to resolve her grief about a recent abortion, but found that discussing this provoked vehement condemnation from two other members. The division of the group over this issue threatened its capacity to function supportively. After a brief "let's agree to disagree" compromise was reached,

the therapist was able to confine examination of this issue to individual contacts.

A seventh strategy for maintaining clients' focus on community reentry used the group therapy setting to showcase their off-unit successes. Several techniques were used to increase generalization of group therapy learning to off-site settings. One tactic for integrating off-unit experiences involved structuring a brief reports period at the start of group sessions. During this period, "good news" is solicited from all group members, and specific inquiries are made about participation in available off-unit activities of various types, including both employment and special training experiences.

Providing brief reports of their experiences with parttime employment allows members the opportunity to receive recognition for their accomplishments, and to learn about available options open to those in treatment. The group discussions that result challenge negative stereotypes about those suffering from mental illnesses, by providing irrefutable evidence that many of those with severe illnesses can function quite capably in a variety of settings. This information about peers often transforms relationships among residents, helping them to see each others' strengths, and to appreciate the potential resource provided by their collective experience with life and treatment.

Providing brief reports about various ancillary treatment experiences informs all group members about available training options, increases motivation to participate in future weeks, and allows for consolidation of new learning by giving patients the opportunity to describe what they learned and how they are beginning to put this to practice. This serves to amplify the impact of available off-unit treatment experiences. For example, a patient participating in a special computer skills course can use the group forum to explain how to use a mouse and menus to all members, including those who are still too intimidated by technology to attend such training. This can help to desensitize group members who were previously afraid to engage in such training, while giving the "teacher" the chance to rehearse their skills and gain respect for taking the risk to undertake this new challenge.

Since patient attendance in the groups used to evaluate these interventions started fairly high and gradually increased as the tone of meetings became more positive and mutual cheerleading became more the norm, it was important to ensure that all attendees had the opportunity to participate. Use of a simple, structured, brief "mood check" (Are you having a good day, neutral day, or rough day?) with all patients at the beginning of every meeting alerted the leader to particularly demanding crises and afforded all members the opportunity to voice concerns. After attending to any pressing "new business", efforts were made to systematically explore for instances of off-unit successes. Inquiries about treatment mall experiences in the previous week (Which modules did you sign up for? How did you do?) and questions about employment experiences were used to solicit discussion about off-site experiences. Members were also asked if home visits and other off-unit experiences had provided them with any opportunities to practice some of the coping strategies they had discussed during previous group meetings. Explicitly tying group content to applied settings beyond the formal treatment setting helped patients see the relevance of their treatment experiences. It also seemed to maintain their focus on discharge planning, rather than on acclimating to the hospital environment and focusing on

settling into comfortable relationships with peers.

Method

Forty-two inpatients from three units of a 500-bed state psychiatric institution participated weekly in psychotherapy groups revised to accommodate enhanced individualization. Participants' responses were evaluated over the course of a three month period. Patient surveys were conducted at monthly intervals, in order to assess patient satisfaction with the several strategies being used to tailor treatment provided in weekly group psychotherapy meetings. Baseline measures of patient satisfaction with the group treatment program were obtained before the new strategies were implemented. Measures of patient behavior within the group program were also collected, in order to assess the stability of patients' behavioral gains. Measures of problem behavior episodes on the treatment unit were obtained for both a 1-month pretreatment and a 1-month posttreatment period. Pre and posttreatment comparisons were used to assess the behavioral impact of these attempts to tailor treatment more systematically.

Coordinating Care with Individual Treatment Plans

Development of groups was based on the individual patient needs specified in members' treatment plans. Common objectives and goals were identified, and appropriately focused groups were created (e.g., a Decision-making group for members who shared common difficulties in making safe and constructive decisions in their lives). In each patient's treatment plan, the basis for all activities on the ward, there are listed short-term objectives that the patient is supposed to accomplish as steps toward a long-term goal. The goal in each case is based on controlling the problem that caused the present hospitalization. Many of the patients were hospitalized because their behavior made them unacceptable to the group homes in which they had lived. Goal Group sessions were used to permit patients to discuss what they need to do while in the hospital in order to facilitate discharge. The objectives in these cases might involve accepting reality-based feedback from staff demonstrating appropriate social interaction with peers. Some patients have difficulty in focusing attention long enough to handle the ordinary personal and interpersonal activities of daily life. The objectives in these cases might involve focusing attention long enough to proceed with a task or topic for a certain period of time (e.g. five minutes).

In order to provide a positive experience for each patient, and to work toward accomplishing the objectives, the therapist needs to be flexible in choosing programs, presenting topics and tasks, and encouraging appropriate interactions. Often it has proved valuable to utilize the services of therapists from more than one department, to give patients a variety of experiences within a group. For example, the psychologist has led a half-hour discussion, then encouraged and joined exercises led by an occupational therapist. The group then had music and discussion, co-led by a music therapist and the

psychologist.

Results

Measures of patient satisfaction showed that group members welcomed the more individualized approaches to conducting group psychotherapy meetings. Attendance improved following incorporation of these techniques for accommodating patients' individual needs and providing tailored learning experiences within the group. Participation within the group, and engagement in therapeutic conversations visibly improved after these new strategies were implemented.

Preparing the PowerPoint summary of treatment was of considerable interest to many of the group members. Since involvement in this phase was entirely voluntary (it was presented rather informally, as a chance to help the leader out), the fact that the majority of the patients approached agreed to participate on at least two occasions, suggests that this may be a useful way of augmenting the learning that occurs in group treatment. This experience provided obvious didactic benefits (the repetition of information improved subsequent retention rates), and it also helped to improve the computer literacy of the participants. This is especially important today, when many patients feel quite alienated from the larger society and from many workplaces simply because their illness has blocked their access to this increasingly central technology. Exposure to these tools in a supportive, unpressured context helped many of the patients feel far more comfortable with the idea of getting additional computer training.

Strategies that were used to modify the large group meetings succeeded in providing needed social stimulation for both low-functioning and high-functioning patients, and gave patients increased opportunities for guided interactions. This program was satisfying to the participants and led to progress toward the patients' treatment objectives. High-functioning patients were helped to provide assistance to their lower-functioning peers, who in turn expressed satisfaction about what they had been able to remember. Outside of formal group meetings, the peer mentoring approach resulted in the creation of several mutually supportive patient dyads (for example, one woman who loved to cook took a recovering anorectic patient who wanted to learn healthful recipes under her wing; in turn, the cooking student taught her mentor the basics of word processing).

The intentional use of group therapy meetings to showcase group members' off-site successes was found to increase group attendance, participation, and reports of perceived efficacy among group members. In addition, members proved to be a very valuable resource to one another. They consistently provided helpful detailed suggestions about opportunities within the larger community.

One large group gave rise to a patient-led "literary society". This group now meets during the weekend, without staff supervision, to discuss short poems, cartoons (primarily from the New Yorker), and biographies selected by group members. As a result of participating in this experience, several group members have started using their journals to start writing their own poetry and short stories. This initiative testifies to the therapy group's success in fostering a greater sense of community, mutual respect, and greater

perceived self efficacy among individual members.

Discussion

These findings suggest that some of these strategies for offering flexible group experiences may be a practical way of improving treatment delivery while working within budgetary constraints. The patients seemed to welcome the efforts made to address their individual treatment needs more systematically. These approaches were more effective with patients drawn from the unit populated by younger individuals (mean age of 39 years) than with more geriatric individuals needing greater nursing care. While the older patients reported success experiences with treatment activities involving music activities and discussions and interactions with pets, they were less apparently satisfied with other educational modules provided.

The experiences of group members during this period of observation offered further support to previous findings about the advisability of offering patients increased control over the nature of their group therapy experiences. As has been found in several earlier assessments fo related group therapy strategies, offering patients the opportunity to select topics for group discussion, the size of therapy group, the time of therapy group, etc. are all associated with increased engagement in therapy

However, several factors limit the conclusions that may be drawn here. First, since no control group was used in this study, a variety of other factors could have contributed to the observed changes from pretreatment to postreatment. It may be that increased familiarity with group leaders was responsible for the improvements in participation and engagement. However, it is important to note that roughly half of the patients participating in these groups had known the psychologists leading their groups for at least 3 years. This suggests that simple increases in comfort with the leader did not account for all the observed gains. Future research using a randomized control design would clarify the actual effects of participating in these integrative groups experiences.

In recent years, the expectations of group therapy have increased, forcing group therapists to be more inventive. Therapists are expected to use empirically supported treatment methods, and to evaluate their effectiveness by monitoring individual patient outcomes. Effecting measurable behavioral change has supplanted providing support as the goal of treatment. Maintaining stable functioning within the institution is no longer seen as sufficient; therapists are expected to help patients develop and implement specific new skills. Escalating pressure to discharge patients more quickly has also compelled therapists to develop more effective techniques. The strategies described in this study may help others interested in customizing patients' therapy experiences.

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Chambliss, C.A. Psychotherapy and Managed Care, Allyn & Bacon, 2000

Chambliss, C.A. Group Involvement Training, New Harbinger Publications, Inc. 1988

Appendix I

Kaleidoscope Computer Class

2002

Tips for handling tough families

- Reduce your expectations!
- Try to appreciate little things
- Reciprocate when you can
- Focus on the positives

Welcome to Our PowerPoint!

- This PowerPoint presentation has been developed over the course of several months by participants in our Computer Training classes. Each week we gather to develop a page that reflects themes from our treatment experiences. Most pages summarize coping strategies that members have found effective.

Letting Go of Anger

- Forgiveness is freeing
- ANGER WASTES ENERGY
- Try not to take things personally
- Consider why someone did what they did...the reason might be benign

How to handle a difficult dad

- Give him space
- Give yourself space
- Don't take everything to heart
- Don't take things too personally
- Be honest with each other
- Let things calm down
- Discuss the problem with him
- Be calm and assertive
- Think about his good points
- Think about YOUR good points!

How to have reasonable expectations

- Ask yourself if you expect too much from yourself
- Ask yourself if you expect too little from yourself
- Decide to find the right balance

The trouble with Unrealistic Expectations

- Expecting too much from YOURSELF:
- You may never feel that you are doing enough
- You may feel discouraged
- You may feel like a failure
- Expecting too much from OTHERS:
- You may always feel disappointed
- You may be angry
- You may feel hurt or rejected

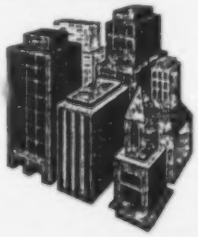
Solving the Stigma Problem

- Teach people that mental illness can be successfully treated!

Tips for Avoiding Depression

- Stay Flexible!
- Remember that there are many options that may be workable.
- Don't get stuck thinking only one solution will work
- Avoid all or nothing thinking!
- Stay patient!
- Remember that it may be necessary to use "stepping stones" to get to your final goal

Tips on using Imagery



- 1. Choose a positive memory from your past
- 2. Think about how the situation looked.
- 3. Think about how the situation sounded

Strategies for Helping depression

- 1. Seek out others early on
- 2. Avoid Negative thoughts
- 3. Distract yourself! Stay busy!

Using IMAGERY as a Coping Strategy

- Imagery can help you to transform a bad situation into a good situation. By thinking about a comforting, peaceful scene from your past, you can get through a rough time.

Imagine a relaxing scene

- 4. Think about how the situation smelled.
- 5. Think about how warm or cool you felt.
- 6. Were there any breezes?

HOW TO DEAL WITH FEAR

- CALL A FRIEND
- TURN ON TV.
- PUT ON MUSIC
- TAKE A WALK
- WRITE IN A JOURNAL
- TURN ON ALL OF THE LIGHTS
- TAKE A WARM BUBBLE BATH

Steps to increasing the unit's therapeutic power

- Helpful Resident behaviors:
- Speak Calmly
- Listen Carefully
- Notice positive steps
- Give feedback gently
- Show Respect
- Expect respect

- Helpful Staff behaviors:
- Speak Calmly
- Listen Carefully
- Notice positive steps
- Give feedback gently
- Show Respect
- Expect respect

HOW TO DEAL WITH MENTAL ILLNESS

- LAUGH AT YOURSELF
- LAUGH AT THE PEOPLE WHO THINK THEY ARE SANE
- ACCEPT IT
- READ ABOUT IT
- EDUCATE OTHERS
- IGNORE THE STIGMA

How to have Peace of mind

- Pray to God
- Handle your problems
- Be assertive
- Be free and open to suggestions
- Accept what can't be changed

REACTANCE: Why it's tough to follow heavy-handed rules

- When you feel like you're being forced to do something, you often feel like doing exactly the opposite of what you are being forced to do. This is sometimes called being oppositional
- or contrary.
- Rules can take the fun out of doing what you'd want to do anyway
- The big trick is to keep the rules from getting in your way
- Another challenge is to keep from being angry all the time because of the rules

Handling Bad Feelings

- Pray
- Take meds
- Exercise
- Read
- Listen to Music
- Dance
- Sing
- Rethink things
- Try to trust
- find support
- think about Bloomin' Onion
- Take relaxing breath

Why Assertiveness works best

- Being PASSIVE prevents others from knowing what you want
- Being passive can leave you feeling resentful
- Being AGGRESSIVE tends to make others defensive or aggressive
- Being aggressive can scare others and make them avoid you...leaving you lonely

Favorite Programs

- Solitaire
- Typing
- Word
- Powerpoint

Coping with Boredom

- TV
- READING
- cards
- singing

Coping with People

- Passive
- Assertive
- Aggressive

Coping with extremely difficult situations

Remember:
THIS TOO SHALL PASS !

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